

Arkansas Health Care Payment Improvement Initiative Stakeholder Survey Results Summary

A public survey was fielded from May 26th-June 30th, 2011. 100 responses were received, with 7 of the surveys left blank (n=93)¹. The following is a summary of the responses received and the themes that developed within each question.

1. Please provide any comments on any of the potential priority items discussed at the May 26th meeting.

Respondent comments tended to group around some similar theme areas. Below is a breakdown of the number of comments related to each identified theme:

- Chronic conditions: DM: 21, HTN: 16, COPD: 10, CHF: 10, Heart Disease: 3
- Prevention: 20
- Mental and/or behavioral health: 12
- Patient compliance/education/engagement: 6
- Reference to current CHC model: 4
- Dental: 3
- Neonatal/NICU: 3
- Prenatal/pregnancy: 3
- Infections: 3
- Hospice: 2
- Cancer: 2
- All: 2
- No response: 17

Summary: Respondents to the survey assisted the Arkansas Health Care Payment Improvement Initiative in validating several of the priority areas under current consideration.

Sample responses:

“Due to the high incidence of dx and high level of readmission to hospitals, consider adding pneumonia and other respiratory infections and acute myocardial infarction (AMI) to the list.”

“Important that appropriate medications are covered. What is planned in the way of patient education/support for "managing" their chronic disease?”

“A statewide neonatal network based upon recent data published in the Journal of the AR Medical Society demonstrates our opportunity to designate "levels" of neonatal care in AR to improve outcomes. The management of all newborns but especially premature newborns could reduce AR neonatal and infant mortality to improve our national rankings. We have all the pieces in place to accomplish this goal. AR is one of a very few states that does not have Level 1, 2, 3 designations for nurseries and neonatal care. This also allows for an accountable and measurable opportunity to reduce costs while monitoring outcomes and improvement. If the follow up for these highly vulnerable and costly patients could take advantage of an expanded "Medical Home" program, the longer term outcomes and cost could be improved. AR has demonstrated this project through the Medical Home for Medically Complex Children at ACH. That program linked to the neonatal network statewide could make a tremendous difference and put AR at the cutting edge in this population of patients.”

“These are all very good potential priorities. Diabetes, Hypertension, COPD, CHF, Preventive Care, Mental Health IHD are really needed in our area.”

¹ Responses will not total 93, as respondents often commented on more than one theme area in their response.

2. Other than the areas above, describe any additional disease states or health conditions where you see inefficiencies. Please provide as much detail as possible.

Additional priority areas respondents felt they saw inefficiencies included:

Obesity: 15
Dental: 8
Access to appropriate care: 5
Teen pregnancy: 4
End of life care planning: 4
Cancer: 4
Mental and/or behavioral health: 4
Home health care: 3
Prevention: 3
Medical Homes: 2
Patients falling in between the cracks: 3
Patient medical records: 2
Other items (1 each): ALS coordination of care, appropriate ventilator step-therapy
Auto-immune/Connective-Tissue Disease, HIV, TB, STDs, injuries, wound management programs, minority health, and transportation needs
N/A: 18

Summary: Several important areas were uncovered through participant responses that were not previously highlighted by the Arkansas Health Care Payment Improvement Initiative. Items such as those above will be taken into consideration with the help of current Arkansas data to better assess whether there are feasible opportunities for health system improvements in a particular area.

Sample responses:

“Access for Medicaid drug dependant patients for inpatient and outpatient treatment needs to be addressed. Access to physicians for outpatient treatment needs to be improved.”

“Obesity is a condition that leads to many illnesses- needs attention in youth groups and healthier eating.”

“Cancer, a lot of the patients are faced with no income, transportation needs, nutritional needs. Some of these fall between the cracks as far as Medicaid eligibility.”

“Arkansas spends over \$500,000,000 per year on institutional care for the aging and physical disability populations, i.e. non-MR/DD. Of long term care expenditures, approximately 71% is for institutional care while only 29% is for community long term care expenditures. Data shows that on a per capita basis, community care is less expensive than institutional care. While states have been concerned about the “woodwork” effect of community care, recent data shows long-term care spending growth was greater for states offering limited non-institutional services than for states with large, well-established non-institutional programs. The authors state “Justification based on financial constraints can no longer be credibly offered as reasons for forcing people into nursing homes and other institutions. Home and Community Based Services may be one instance in which offering people greater choice also helps reduce costs.” Source: H. Stephen Kaye, Mitchell P. LaPlante and Charlene Harrington, Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?” Health Affairs, 28 no. 1(2009):262-272.”

3. In as much detail as possible, please describe your suggestion for improvement of the specific diseases or conditions and their related positive outcomes. (i.e. What is your proposed path for change? What could be done better in this area? How will this affect positive change?)

Following are the general themes represented by the respondent comments:

N/A: 12

Care coordination: 10

Use local health units and local community resources: 10

Increase funding for lifestyle programs (tobacco, obesity, etc): 5

Use physician extenders for primary care: 5

Chronic disease management programs (e.g. Stanford Chronic Disease Self-Management Program): 5

Prevention: 5

Patient Navigators: 4

Education (patient): 3

Behavioral health facility reimbursement for adult Medicaid members: 3

Patient centered medical homes: 3

Access to care and insurance: 3

Utilize in-home health care: 3

Hospice / end of life care: 2

Medication assistance for elderly: 2

Universal assessment for long-term care: 2

Other items (1 each): create state pediatric network of care; bundle neonatal care; transparency in MMIS data; electronic health records; dental school tuition reimbursement for rural practice agreement; health literacy; limit food assistance programs to healthy options; promote tort reform; utilization management; pre-authorization

Summary: Several detailed scenarios for specific diseases or conditions were provided; many focused on care coordination and patient-centered care planning and transition.

Sample responses:

"It would be helpful if financing could be arranged that could allow for the overall management of the chronic diseases rather than care being provided by multiple providers without good coordination of care."

"Identification of at-risk high resource utilizers would be necessary, along with a tiered level of services such as dedicated care coordination. By identifying these children prospectively, care coordination can keep these children in the community and out of the hospital. Several methods of identifying children in administrative databases do exist (Feudtner's Complex Chronic Conditions; 3M's Clinical Risk Groups) albeit not perfect. Optimal care coordination improves access and reduces unnecessary tests, thereby resulting in more timely and appropriate care."

"Hospice care is the gold standard of care for patients at the end-of-life. If more patients were informed about this option and chose hospice it would allow patients and families to receive compassionate high quality care that is delivered in a cost effective manner. A study commissioned by the National Hospice and Palliative Care Organization and conducted by Millman USA, showed that hospice saves state Medicaid programs approximately \$7,000.00 per Medicaid hospice beneficiary. This is done through preventing unnecessary hospitalization, providing medical equipment and supplies under hospice and reducing the amount Medicaid pays for terminally ill patients residing in a nursing home (in Arkansas that amounts to almost \$1 million in savings.)"

4. Are there barriers in the current system that would need to be overcome in order for your suggested improvements to occur?

Barriers identified by respondents grouped around several themes, outlined here:

Money/funding/finances: 11

Billing for prevention/counseling/education (knowledge of): 6

Patient education: 5 / Legislature education: 1

Barriers to access for legal immigrant children (5 year wait): 5

Home health care vs. nursing home care (appropriate placement): 5

Medicaid enrollment/reenrollment for children: 4

Yes: 4

Lack of PCP's: 3 / Use APNs: 1 / Use other health care providers (team): 2

Lack of HIT/HIE/broadband: 3

Lack of insurance access: 2

Tort reform needed: 2

Pre-certification and utilization review process needed: 2

Changing environmental policy & social determinants of health: 2

Transportation: 2

Pediatric care: 1

Lack of dental program: 1 / Lack of medical facilities: 1 / Lack of higher education facilities: 1

End of life planning non-reimbursement: 1

Language barrier: 1

N/A: 16

Summary: There were multiple barriers that were highlighted by respondents. These barriers will need to be considered by the Arkansas Health Care Payment Improvement Initiative and stakeholder workgroups upon further evaluating each priority area under consideration.

Sample responses:

"Yes there are barriers to care. There is a lack of preventative care, a lack of care to legal immigrant children, health disparities and lack of coverage for the Marshallese residents. People who can't access care have no choice but to go the ER for healthcare. Their needs could be addressed much more cost effectively through providing them access to affordable care. Patients often do not seek out specialty services when referrals are made."

"Reimbursement for providing patient self-management training is lacking. We also need funding for health care agencies to do electronic remote home-monitoring of their patients while they are learning self-management skills."

"a) Lack of emphasis and reimbursement for wellness strategies. b) Systems that work in silos and independently that do not encourage integrated care for the whole person c) Lack of HIT assistance d) Lack of transportation e) Need for meaningful, real-time data from Medicaid f) Lack of centralized eligibility for all social services, e.g., Medicaid, TEFRA, AFDC, Food Stamps, WIC, etc."

"The biggest barrier would be educating the public to taking responsibility for their healthcare."

"Funding and staffing if local health units were to implement programs to educate and monitor on diseases."

5. Why do you see this as a promising area for initial exploration? (i.e. necessary provider groups are already prepared, major cost driver, impacts a broad group of beneficiaries)

Survey respondents identified the following areas as reasons why their specific disease, condition or health system change are ripe for initial exploration:

Item is a major cost driver: 18

Necessary provider groups are already prepared: 14

Item impacts a broad group of beneficiaries: 12

Community based initiatives are already focused on many of these items: 2

N/A: 22

Others: already have momentum; multiple studies document the quality and efficiency of care by APNs; other state entities (HIT) already have some traction; proven helpful in other states

Sample responses:

“Because it encompasses the age diversity in this county.”

“A lot of the general public do not like going to the doctor’s office. Across the board they do not get consistent education, every PCP office is different. These areas are where we can affect the overall health of the patient.”

“The long-term care assessment process DHS is currently working on. Strong track record of community services.”

a) The existence of this review process indicates that there is a desire to improve overall states of public health in Arkansas, to reduce costs, and to improve efficiency. b) DD providers already serve as de facto health homes, and could do so more effectively with recommended changes.

6. Please provide any other comments, solutions or suggestions you would like captured.

Respondents ‘other’ comments related to several previously suggested areas of interest, including:

Community based health services and long-term care (may not fit into episode groups, need of major revamping, Medicare and Medicaid are not coordinated, criteria for PCP for referring): 6

Provider & Payment: (hold providers to the same standards, all services to all at every visit, pay by team, state and provider cooperation on the rate setting, incentive to get more providers to come to rural counties, reward quality and cost savings): 6

Patient engagement & education (also health system navigation by the patient / community education funding needed): 5

Nutrition (cost of fresh fruits & vegetables / poor diet / subsidize fruits & vegetables / apply for grants to fund dieticians): 4

Must consider population, social determinates of health, education, cultural diversity and transportation as you build bundles: 3

Behavioral and mental health (convene an exploratory meeting with behavioral health and primary care): 2

Focus on self-management and chronic disease self-management: 2

Organize and develop a statewide pediatric network (forum): 1

Do not allow direct marketing of medications that require a prescription: 1

Consider immunizations in episodes of care creation: 1

N/A: 61

Summary: Additional comments were gathered on a variety of areas; many have clear intersection with several prior recommendations received throughout the survey.

Sample responses:

“Must consider social determinates of health, education, and transportation.”

“Carefully examine cost savings of providing community based services (long term care) and ensure increased quality and savings before changing the system of care. State and provider cooperation on the rate setting.”

“Allowing free standing psychiatric facilities to provide services to adult Medicaid patients.”

7. Health profession:

Respondents were asked to identify their profession:

Medical provider: 39

Health System Administrator: 25

Consumer/Patient: 2

Voluntary Organization: 2

Research Organization: 0

Other: 31

N/A: 3

(Other: ADH; Area Agency on Aging (2); Arkansas Optometric Association; CEO; Chairman - Department of Pediatrics; Childcare Provider; Community organization; FQHC; Health Department; Health Unit Administrator (2); Hospice; Hospital Administrator; In Home Service Provider; Medical Cost Management and Quality Care Organization Membership Organization; Operations Director; Regulatory agency; Public Health (6); State government; (501(c)(3), independent public charity)

8. County:

Respondents were located in 49 different Arkansas counties:

Arkansas: 3

Baxter: 1

Boone: 2

Calhoun: 1

Clark: 1

Clay: 1

Cleveland: 1

Columbia: 1

Craighead: 2

Crittenden: 1

Cross: 1

Faulkner: 3

Garland: 2

Grant: 1

Greene: 1

Hot Spring: 1

Howard: 2

Independence: 2

Izard: 1

Jefferson: 3

Lee: 2

Lincoln: 2

Little River

Lonoke: 1

Lonoke: 1

Madison: 1

Marion: 1

Miller: 1

Mississippi: 5

Montgomery: 2

Newton: 1

Ouachita: 1

Perry: 1

Phillips: 1

Pike: 1

Poinsett: 1

Polk: 1

Pope: 5

Pulaski: 22

Randolph: 1

Scott: 1

Searcy: 1

Sebastian: 1

Sevier: 1

St. Francis: 1

Union: 1

Van Buren: 1

Washington: 3

Out of state

response: 2

N/A: 4

Individual responses can be viewed at: <https://ardhs.sharepointsite.net>

As priority area workgroups are formed, summaries of related comments will be provided to the workgroups. Additionally last year's efforts to capture suggestions via the *Bending the Cost Curve* process will also be provided to workgroups and utilized by the Arkansas Health Care Payment Improvement Initiative. Some of the themes discovered through last year's process parallel well with the continued work to bend the cost curve. This report will also be integral as the initiative moves forward.